PERSONAL INFORMATION

(PLEASE PRINT)

Name of Patient: _____

Date of Birth: ____-____-_____ Age:_____ Sex: _____ SS#: ____-____-____

Address: _____
Street City State Zip

Employer: _____

Primary Phone #: ____-____-_____ Secondary Phone #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

E-Mail Address :_____

Complete if patient is under 26 and is on parent's insurance policy

Father : _____
Address: _____
Employer: _____
Primary Phone #: ___-___-____
Date Of Birth: _____
SS#: ____-____-____

Mother : _____
Address: _____
Employer: _____
Primary Phone #: ___-___-____
Date Of Birth: _____
SS#: ____-____-____

Pharmacy Information

Pharmacy Name_____
Pharmacy Address: _____
Pharmacy Phone Number: _____-_____-_____

Race:
☐American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other _____
Primary Language spoken: _____

Insurance Information

Primary Insurance: _____ Insured: ☐ Self ☐ Spouse ☐ Parents ☐ Other
Secondary Insurance: _____ ☐ Self ☐ Spouse ☐ Parents ☐ Other
Tertiary Insurance: _____ ☐ Self ☐ Spouse ☐ Parents ☐ Other

Primary Insurance Carrier (if not self): _____ Date Of Birth: ___-___-____

Are you over 65 years of age? ☐ Yes ☐ No If yes, continue answering questions below
Did you have a flu shot between October 1st and March 31st? ☐ Yes ☐ No ☐ Not between Oct-Mar
Have you ever had the pneumonia shot? ☐ Yes ☐ No ☐ Unknown
Have you fallen in the past 6 months? ☐ Yes ☐ No In the past 3 months? ☐ Yes ☐ No
If yes, were you injured in the fall? ☐ Yes ☐ No

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____
PRINTED NAME SIGNATURE

_____
DATE